curve upwards of the sacrum. Speaking of these boundaries, it is understood that the patient lies in the Trendelenburg position.

The quantity of gauze introduced will depend upon circumstances. Sometimes as much as three or four yards are used, but generally from one to two will suffice to fill the pelvis with a fair amount of pressure upon the bleeding points.

When the pelvis has become filled, I introduce a rubber tube, 1 cm. in diameter, by making a channel for it with the forefinger of my left hand between the posterior face of the uterus and the gauze pack. About 1 in. of the gauze is left outside the wound alongside the end of the rubber tubing. The wound is then closed: first, by applying a running suture to the divided peritoneum, and then the closure is completed by passing interrupted silkworm gut sutures through the skin, fatty tissue, and aponeurosis. Muscle tissue is never included. This gauze is allowed to remain all the way from forty-eight hours up to thirty days, and I have never yet been able to make a culture from the fluid it contained; and it should always be so, provided it is introduced thoroughly aseptic. If the gauze is withdrawn within eight or nine days following its insertion, it gives some pain, but after that it becomes completely surrounded by serum in its tract, and is withdrawn with ease. The tract seems to close very rapidly round the rubber tube which has been left in. This tube is withdrawn, and half an inch to an inch removed every day until the wound closes from the bottom upwards and no more discharge follows. The cases in which this method of treatment has proved successful in my hands are those in which constant oozing went on, and in many instances the patient died from hæmorrhage or exhaustion.

During the convalescence of the patient it is remarkable how little pain is complained of from the pressure of this gauze in the pelvis; also it does not interfere with the action of the bowels, either when moved unaided or by medicine. The principle upon which it acts, I think, depends upon the rapid formation of blood clot between the bleeding surfaces and the layers of gauze. This clotting seems to arrest further bleeding by occluding the mouths of the small vessels. This thin layer of blood clot is afterwards absorbed or becomes organised, being aseptic.

The following is a summary of some of the cases in which gauze packing has been used in my clinic:

2	cases of pus tubes in which it was removed in 24 hours.	
7	"	"
2	"	" on the 3rd day
4	"	" 4th "
1	"	" 8th "
1	" cystic ovaries	" 3rd "
1	" ovarian tumour	" 3rd "
1	" hæmatomata ovarii	" 2nd "
1	" double pus tubes	" 7th "
1	"	" 2nd "
1	"	" 8th "
1	"	" 10th "
1	"	" 8th "

1 case of ectopic gestation. In all 25 cases.

In the last case the abdomen was opened a second time for hæmorrhage within two hours of the first operation. The pelvic cavity was found filled with blood from general oozing. This was cleaned out, a gauze packing inserted, and no more hæmorrhage took place. The patient made a good recovery.

SOCIETY FOR THE STUDY OF INEBRIETY.—At a meeting held on October 14th, the President, Dr. Norman Kerr, in the chair, Surgeon-Major G. K. Poole, M.D., read a paper on The Etiology of Inebriety. He presented the opinion of a large number of clergy, laymen, and medical practitioners. With the exception of one medical man the testimony was affirmative of heredity as a predominant factor, and of business and domestic distress and worry being causative in a substantial proportion. Some non-medical reporters attributed up to 50 per cent. as being consequent on "doctors' orders"; but Drs. Hare, Morton, Aydon Smith, Longhurst, Paramore, and the President repudiated the accusation, the President stating that in not more than $\frac{1}{2}$ per cent. of over 2,000 cases could he trace anything of the kind. Dr. William Bode, of Hildersheim, stated that in January, 1900, the new German code would operate for interdiction and compulsory dealing with inebriates.

A CASE OF PERFORATION OF THE APPENDIX VERMIFORMIS AND PERITONITIS : OPERATION : RECOVERY.*

By OSMUND STEDMAN, M.D., B.S.LOND.

L.M., female, aged 23, first came under my care in December, 1895, suffering from a severe attack of appendicitis; a considerable mass formed on the right iliac fossa, and extended so far that it could be felt *per vaginam*, filling up the right side of the pelvis. On that occasion I was much inclined to operate, thinking that pus formation had occurred, but after some time the symptoms gradually improved under medical treatment, namely, opium, enemata, hot fomentations, and counter-irritations, till after an illness extending over six weeks the patient appeared to be completely recovered, and the whole of the exudation round the appendix had disappeared.

In June, 1896, she had a second attack similar to the first, although not so severe. Her illness on this occasion lasted about three weeks; this time, also, the right iliac fossa contained a mass of exudation, but it did not extend down into the pelvis, as in the first attack. In addition to these two severe attacks she was on three other occasions laid up for three or four days with pain and tenderness in the right iliac fossa, which passed off without the formation of any inflammatory thickening, the last such attack occurring in Christmas week of last year.

On March 23rd, 1897, having been apparently in her usual health the day previous, she woke up at 7 A.M., and felt some pain in the anal region. She took a dose of aperient mineral water, and returned to bed and slept till 10 A.M. She then had a cup of coffee, after which the bowels were moved twice; she then proceeded to dress, and while walking across her room was suddenly seized with violent pain in the right side of the abdomen. She returned to bed, but the pain was so severe that she was unable to take off her clothes. Again before doing so, about ten minutes later, a severe attack of vomiting came on.

I saw the case at midday; she then had a temperature of 97.5°, pulse 72, small and thready; there was great tenderness all over the abdomen, the knees were drawn up, the patient was continually groaning with pain, and a severe attack of vomiting occurred while I was there, the vomit consisting of bile-stained fluid.

I administered a third of a grain of morphine hypodermically. At 5 P.M. one of my colleagues saw the case with me; the symptoms were unaltered, except that the pain was not quite so severe, and reaction had set in; the temperature was 99.5°, the pulse 96, full and running. She had had another attack of vomiting during the afternoon. I decided to send the case to hospital, with a view to operating early the following morning.

On arrival at the hospital the patient had another severe attack of vomiting, the temperature being then 100°. Meanwhile all instruments, etc., likely to be required were boiled for three quarters of an hour, and put into stoppered jars ready for use.

The following morning, March 24th, the symptoms were much the same, the temperature 100°, the pulse 96. There had been no more vomiting during the night, the patient having been kept under the influence of morphine. A vaginal examination was made by Dr. Hartigan, but nothing abnormal was found.

The operation was commenced at 9 A.M., that is, twenty-three hours after the occurrence of perforation. Dr. Hartigan administered chloroform, and Dr. Rennie assisted me.

The skin was first washed with soap and water, and afterwards with a 1 in 1,000 biniodide solution. A three-inch incision was made along the right border of the rectus muscle, the centre of the incision being opposite the anterior superior iliac spine. On opening the peritoneum both parietal and visceral layers were seen to be brightly injected and inflamed. The incision not being large enough, it was extended downwards for half an inch, and, in so doing, a

* Read before the Hong Kong Branch of the British Medical Association.

branch of the deep epigastric artery was divided, which gave rise to some trouble.

The small intestine presented at the wound, and some two feet were drawn with a view of reaching the cæcum, but failing to find it the bowel withdrawn was returned and drawn out in the opposite direction; almost directly the ileo-cæcal junction came into view, and as it was being drawn out a few flakes of yellowish lymph escaped. The ileum, cæcum, and appendix were matted together by adhesions, the appendix being bound down into the angle between the ileum and cæcum; with considerable difficulty the appendix was separated, and a perforation was then seen at about the middle of its length, and in the base of the ulcer a small piece of hard faecal matter, about the size of a hemp seed, was lying; on the surface of the cæcum was some yellow lymph where the appendix had been adherent, making it appear that the ulcer in the wall of the appendix had first perforated into a small closed space surrounded by adhesions between the appendix and the cæcum, and that this cavity, containing a few flakes of pus, had ruptured into the general peritoneal cavity at the time of the onset of the acute symptoms. The whole appendix was not more than an inch in length, so that there did not seem to be room to cut it off entirely clear of the perforation: the appendix was therefore divided through at the seat of the ulcer. The muscular and peritoneal coats were then stripped back like a glove from the mucous membrane, the latter was tied as close up to the cæcum as possible and cut off close to the ligature, the muscular and peritoneal coats were then brought down and stitched over the stump of mucous membrane. The bowel was then washed and returned into the abdomen. The abdominal cavity was then well washed out with plain boiled water at a temperature of 100°. A large rubber drainage tube was put into the upper angle of the wound, its lower end resting in the angle between the ileum and cæcum, the abdominal wound was closed with four deep sutures going through all the layers, and two or three superficial skin sutures. There was hardly any shock from the operation, the temperature only falling to 99°; a fifth of a grain of morphine was given hypodermically, and nothing allowed by the mouth except occasional teaspoonfuls of hot water to relieve the thirst. The same evening the temperature rose to 100.4°, the highest point it reached, the dressings were changed, as there had been a considerable amount of blood-stained oozing from the tube; 7 ozs. of urine were drawn off by the catheter.

The following morning (March 25th) the patient twice vomited some bile-stained fluid. The temperature was 99.4°; the dressings were again soaked and had to be changed. The abdomen was not distended, and there was very little tenderness except round the wound; passed urine naturally during the night; was given Brand's essence every three hours during the day.

March 26th. The dressings had to be again changed yesterday evening, but this morning there was no oozing from the drainage tube, which was therefore removed, that is, 48 hours after the operation. Patient does not seem so well, looks dusky, vomited once yesterday and eight or nine times during the night; still the abdomen is not tender or distended, and the wound appears doing well. A soap and water enema, with a tablespoonful of turpentine, was ordered, which brought away several large scybala, after which improvement rapidly occurred, and there was no more vomiting; on the evening of this day, that is, 60 hours after operation, the temperature reached normal, but rose again on the evening of the 27th, and continued between 99° and 100° for three days more, owing to some suppuration in the stitch holes; it again reached the normal line on the sixth day, and there was no further rise. An enema was given every day for ten days, after which the bowels acted daily without any artificial stimulus. The superficial stitches were removed on the 29th, five days after operation, one deep stitch was removed on the 30th, and the remaining three on the following day. There was unfortunately a considerable amount of suppuration from the three lower stitch holes on the outer side of the wound, and although the wound itself healed well the stitch holes were not entirely healed till ten days later, that is, 21 days after the operation.

Fortunately, in this case the symptoms of perforation were sufficiently acute as to leave little doubt as to the diagnosis;

and also the former attacks of appendicitis pointed unmistakably to that region as the seat of trouble. In both these respects the case contrasts strongly with one I reported in the *Lancet*, May 6th, 1893, where a faecal concretion escaped from the appendix, and yet the patient continued to go about during the two following days, so slight was the peritonitis excited, and also there had been no previous attacks of appendicitis.

I have reported the case, as it is another instance that a successful issue may be obtained after perforation and the onset of peritonitis, provided operation be undertaken sufficiently early; yet one cannot help feeling that it would have been better to have removed the appendix in the quiescent period after the second severe inflammatory attack, and thus avoided the extra risk of having to do so after perforation had occurred and peritonitis actually commenced.

CEREBRAL SINUS THROMBOSIS.

By EDGAR TREVITHICK, M.D. CANTAB.,
Physician to the Cheltenham General Hospital.

A GIRL, aged 19, in October, 1896, underwent abdominal section for supposed abdominal cyst, the case in reality being one of tuberculous peritonitis. The abdominal wound never thoroughly healed.

The patient, however, got well enough to leave the hospital, but was readmitted on December 24th, 1896. There was then a sinus at the site of the operation wound discharging curdy pus, and she was reported to be strange in her manner. Early in January she developed very decided "head symptoms," and there was some question about removing her to an asylum. As an alternative, however, she was sent into a medical ward, and came under my care.

There was then very marked want of facial expression, but there was no actual palsy. The mental condition was deranged. The patient was occasionally very noisy and somewhat violent. In the intervals she was placid while left to herself, but very intolerant of any interference. She generally refused her food, which had eventually to be administered, in spite of her active resistance, through a tube. She was very frequently to be found repeating (sometimes singing) hymns and other evidently very familiar songs. She would often appear to be fixing her gaze upon some distant object intently and sometimes rapturously.

She died on March 24th, having continued in much the same condition mentally until the end. There was never any marked palsy of any particular muscle or set of muscles, but towards the end I noticed rigidity of the flexors of the arms.

At the necropsy, in addition to advanced chronic tuberculous peritonitis, I found a firm decolorised thrombus in the superior longitudinal sinus. The main cerebral veins turning in the sinus also contained firm, decolorised, wormlike plugs. The thrombosis did not extend into the jugular veins, and there was evidence that some blood had always been able to pass between the thrombotic cave and the sinus wall. The brain showed a symmetrically-placed patch of hæmorrhagic softening on each side, involving the angular and supra-marginal convolutions. The rest of the brain appeared normal. There was no evidence of tuberculous meningitis. The kidneys were unaffected.

The case is of some interest, I think, on account of the cerebral symptoms which attended the thrombosis.

I may just add that there was considerable enlargement of the post-thoracic glands, which may have exercised some pressure on the superior vena cava.

A VETERINARY CONGRESS.—The third National Veterinary Congress will be held in Paris from November 10th to 14th. Among the questions to be discussed are the generalisation and organisation of meat inspection throughout France; tuberculin and the duty of the veterinarian as regards the sale of animals suffering from tuberculosis; and mallein.

THE annual general meeting of the Incorporated Society of Medical Officers of Health will be held this day, Saturday, October 23rd, at the Holborn Restaurant, W.C., at 5 P.M. The President (Dr. E. Seaton) will deliver his presidential address on Medical Societies and the Public Health Service.